PRINTED: 08/05/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		09G056	B. WING		07/	20/2011	
NAME OF F		·	s	TREET ADDRESS, CITY, STATE, ZIP CO 1321 EMERSON STREET NW WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 000	INITIAL COMMENT	rs	W 00				
W 194	18, 2011 through Jufundamental survey of three clients was five males with varied developmental disa. The findings of the observations at the program, interviews review of clinical an including incident re 483.430(e)(4) STAF Staff must be able to techniques necessar	survey were based on group home and at one day clients and staff and the d administrative records,	W 194	Department of He Health Regulation & Licensing, Intermediate Care Faciliti 899 North Capitol St Washington, D.C. 2	Administration es Division , N.E.		
	Surveyor: 18886 Based on observation verification, the facilic competency in imple			•	·		
	During meal observa p.m., Client #2 was one completed his me room and laid on the ater, a direct care su but and asked the cli	ation on July 18, 2011, at 6:03 bbserved eating dinner. After al, he went to the living living room floor. Seconds apport staff pulled a blanket ent to lay on it.		•			
BOKA VDKX [JIKECTOR'S OR PROVIDE	RASUPPLIER REPRESENTATIVE'S SIGNA	THOSE	TITLE			

Any deficiency statement ending with an asterisk (") denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTR	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G056	B. WING		07/2	20/2011
NAME OF P	ROVIDER OR SUPPLIER ARE II		13	EET ADDRESS, CITY, STATE, ZIP CODE 321 EMERSON STREET NW /ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 227	Interview with the d 2011, at 6:36 p.m., to lay on the floor. intellectual disabilitip.m., indicated that floor, however the s blanket/mat is place. Review of the Clien dated June 2011, o approximately 10:3 maintain an upright after meal. Interview with the Capproximately 11:0 facility falled to Impliprotocol. 483.440(c)(4) INDIVITHE individual progrojectives necessar as identified by the required by paragra. This STANDARD is Surveyor: 18886. Based on observatireview, the facility falled in the required by the required by the surveyor: 18886.	irect care staff on July 18, revealed that the client likes Interview with the qualified es professional (QIDP) at 6:45 he is allowed to lay on the staff must ensure that a ed under him. It #2's mealtime guidelines in July 19, 2011, at 0 a.m., revealed the client is to position for at least one hour library confirmed that the lement Client #2's eating I/IDUAL PROGRAM PLAN fram plan states the specific by to meet the client's needs, comprehensive assessment uph (c)(3) of this section.	W 194	W 194 - The speech and la pathologist will in staff on implement of eating protocol clients in the facil Training on mealt protocols/guideling be conducted by the speech and language pathologist quarte enhance staff cap in implementing the guidelines outline concessed for the months, the facility's House Mill monitor staff meals to ensure the mealtime guideline adhered to as outlined.	in-service ntation ity ime nes will the age arbility he dhe next anager during nat all es are	09/04/11
	Individual Program to meet the client's the comprehensive	Plan (IPP) included objectives needs as recommended from functional assessments, for ints in the sample. (Clients #1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY . COMPLETED		
•		09G056	B. WING		07/2	20/2011
COMP C	SUMMARY STA	TEMENT OF DEFICIENCIES	13 W	EET ADDRESS, CITY, STATE, ZIP COD 121 EMERSON STREET NW (ASHINGTON, DC 20011 PROVIDER'S PLAN OF COR	E RECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
W 227	The findings included 1. During dinner of at 6:00 p.m., reveal teeth. Interview with does not require a 1 meals. Review of Client #1 2011, beginning at a revealed a dental of February 8, 2011. That the client had holeeding. It was recassistance with brustimes per day. Review of the Client Life Assessment da 19, 2011, at 10:00 a labeled oral hygiene that the client require brush his teeth thoroof the IPP dated Oc 2011, at 11:00 a.m., training programs to recommendations in functional assessment. The qualified intelled (QIDP) verified on J 12:45 p.m., that no 1 developed for the clitoothbrushing programs assessments.	pservations on July 18, 2011, ed Client #1 with missing top the staff indicated that he modified diet texture during is medical record on July 19, approximately 8:45 a.m., onsultation form dated. The consultation form noted leavy tarter with heavy commended that he needed shing his teeth two to three it #1's Community & Home ated October 6, 2008, on July l.m., revealed a section in the assessment indicated and physical assistance to bughly and flossing. Review tober 5, 2010, on July 19, revealed no evidence of address the aforementioned included in the comprehensive ent. Citual disabilities professional luly 19, 2011, at approximately training programs had been tent to participate in a sem as recommended in the servations on July 18, 2011.	W 227	W 227, 1 - The Qualified Int Disabilities Profe (QIDP) will review consults for all of the facility - Individual Progra (IPP) of tooth bruwill be developed Client #1 and oth affected by this deficiency - The QIDP will train on implementation program goals - Program goals wing reviewed quarter QIDP for progress of progress and modification mad deemed fit.	essional w dental ients in m Plan ushing d for ers in staff on of the ly by the is or lack	09/04/11
	at 6:03 p.m., reveale	ed Client #3 eating a finely				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		09G056	B. Wi	NG		07/2	0/2011
NAME OF F	PROVIDER OR SUPPLIER			132	ET ADDRESS, CITY, STATE, ZIP CODE 21 EMERSON STREET NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 249	chopped dinner. In missing teeth. Inter that he does require Review of Client #3 2011, beginning at revealed a dental of 15, 2011. The conclient had heavy tal was recommended with brushing his term of the Client Life Assessment day 2011, at 4:00 poral hygiene. The client required physiteeth thoroughly and ated January 11, 2p.m., revealed no eto address the aformic added in the communicipate in a toot recommended in the 483.440(d)(1) PRO As soon as the interformulated a client's each client must retreatment program interventions and sand frequency to stand the second control of the control of the control of the control of the client must retreatment program interventions and sand frequency to stand frequency	e was also observed with rview with the staff indicated ed a finely chopped diet. It's medical record on July 19, approximately 2:50 p.m., onsultation form dated March sultation form noted that the server with moderate bleeding. It that he needed assistance eth two to three times per day. It #3's Community & Home eted January 9, 2009, on July m., revealed a section labeled assessment indicated that the sical assistance to brush his diflossing. Review of the IPP 2011, on July 19, 2011, at 4:30 vidence of training programs amentioned recommendations aprehensive functional		249	W 227, 2 The Qualified Inteller Disabilities Profession (QIDP) will review of consults for all cliens the facility Individual Program (IPP) of tooth brushing will be developed for Client #3 and others affected by this deficiency The QIDP will train soon implementation of program goals Program goals will be reviewed quarterly be QIDP for progress or of progress and modification made a deemed fit.	onal lental its in Plan ing or staff of the by the	09/04/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LULTIPL LIDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G056	B. WII	₩	<u> </u>	07/2	20/2011
NAME OF P	ROVIDER OR SUPPLIER ARE II			132	ET ADDRESS, CITY, STATE, ZIP CODE 11 EMERSON STREET NW ISHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	Continued From pa plan.	ge 4	w:	249			
	Surveyor: 18886 Based on observation review, the facility for received continuous the three clients in the finding includes. The finding includes. Observations, interprevealed that Client exercise program to evidenced by the form day program) arrival home, he we the bathroom. At 4 a snack. Staff went and asked if he ward 4:36 p.m., until 5:20 bedroom. At 5:30 p downstairs and wate attempted to get the games. He played and then indicated if p.m., Client #3 assist dinner. He put the ptable in preparation client and his peers 6:40 p.m., the medicality and began as	views and record review #3 did not participate in his oride a stationary bike, as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		09G056	B. WIN	G		07/2	20/2011
NAME OF P	ROVIDER OR SUPPLIER ARE II			1321 EME	RESS, CITY, STATE, ZIP CODE RSON STREET NW STON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SH ACH CORRECTIVE ACTION SH DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
	2011, at:7:45 p.m., requested to have I him. On July 19, 2011, a #2's Individual Prog 25, 2010, revealed stated, "Three times assistance, he will I minutes per session minutes) 60% of rewas to receive said Wednesdays and F and facility staff were 18, 2011, from 4:12 time was an exercise observation period. Interview with the H July 19, 2011, at approximed that the dexercise activity. 483.460(c) NURSIN The facility must proservices in accordate Surveyor. 18886 Based on observations still review, the facility's client with nursing s	irect care staff on July 18, revealed that Client #3 his shower and staff assisted at 1:00 p.m., review of Client fram Plan (IPP) dated October a program objective which is per week, given physical ide a stationary bike for five in, times three sessions (15 corded trials per month." He training on Mondays, ridays. However, Client #2 re observed on Monday, July p.m. until 8:15 p.m. and at no se activity observed during the ouse Manager and QIDP on proximately 10:30 a.m., client did not participate in the IG SERVICES ovide clients with nursing ince with their needs. So not met as evidenced by: on, staff interview and record nurse failed to provide each ervices in accordance with of the clients residing in the and #4)	Wa		The QIDP will train on accurate documentation of program goals. The facility's House Manager and QID on a weekly basis monitor implementation and documentation program goals for clients in the facility ensure accurate documentation program implementation and data collection be carried out for months to ensure significant emphasization by staff	e P will ntation on of all ity to ata oring of ntation n will three that sis is ata goals nonthly sure gram	09/04/11

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G056	B. WIN	IG		07/2	20/2011	
NAME OF P	PROVIDER OR SUPPLIER			13	ET ADDRESS, CITY, STATE, ZIP CODE 21 EMERSON STREET NW ASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEPICIENCY)	ULD BE	(X5) COMPLETION DATE	
	1. On July 18, 201: observed entering the walker. During medical formedication administration ad	1, at 4:25 p.m., Client #1 was he facility using a seated roller dication observations on July m., revealed Client #1 25 mg. Interview with the urse (LPN) after the tration revealed that the client ation for his diagnosis of 's medical record on July 19, 8:45 a.m., revealed a ation review consultation form. The psychiatrist the client see a neurologist tion in gait. Further review of revealed a neurologist consult PN on July 19, 2011, at 0 a.m., indicated that she all appointments for Client #1. ed that a neurology consult ule. There was no evidence insult had been made after the e recommendation for	W	331	W 331, 1 The facility's Regist Nurse, will on a we basis review all me records to ensure the recommendations are carried out in a time manner for all clienthe facility. A tracking system where the put in place to captor recommendations at timely follow-ups. On a quarterly basificality's RN and Qlareview all medical records to ensure the recommendations adhered to in a time manner.	ekly dical hat are ely ets in will be and s, the DP will hat	09/04/11	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		09G056	B. WING_		07/2	0/2011
NAME OF F	PROVIDER OR SUPPLIER		13	EET ADDRESS, CITY, STATE, ZIP CODE 321 EMERSON STREET NW /ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 331	indicated that she was down the toilet. At nurse was observe medicine cup and a she indicated she purply cup to dissolve the medication nurse fluown the toilet. Interview with the Financial she indication in the solution in the solution in the shear she indication in the shear she	nedication nurse at 7:42 p.m., vas going to flush the tablets 7:58 p.m., the medication d putting the two tablets in a adding water. In an interview put the water in the medicine tablets. At 8:01 p.m., the ushed the undissolved tablets registered Nurse (RN) on July imately 10:30 a.m., revealed bould be disposed of by ations, putting it into a zip lock	W 331	W 331, 2 - The medication no will be in-serviced facility's policy of discarding medica - Once monthly, the facility's RN will rethe LPNs of the facility demonstrate the procedure for discarding	on the	09/04/11
W 369	11:15 a.m., confirm discarding/disposing discarding/disposing as a controlled drugs, for sample. 4. [See W369] The medications were a cone of the five client 483.460(k)(2) DRUG The system for drug that all drugs, includes elf-administered, as a controlled drugs, included the controlled drugs and the controlled drugs.	e facility failed to maintain pt and disposition of all r one of three clients in the e facility failed to ensure that dministered without error, for ts residing in the facility. G ADMINISTRATION	W 369	W 331, 3 - Cross Reference W W 331, 4 - Cross Reference W		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		09G056	B. WING		07/2	20/2011
NAME OF F	PROVIDER OR SUPPLIER] ·	REET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 369	review, the facility formedications were a one of the five client (Client #4) The finding include: Observation of the July 18, 2011, at 6:: was administered L Zyprexa, Mirtazapir Metoprolol tart. On review of the client's record (MAR) and crevealed that Theorem	ailed to ensure that drininistered without error, for ts residing in the facility.	W 369	The facility's medic nurses (LPNs) will I serviced on proper documentation of medication not administered The facility's RN will weekly basis review Medication Administration Rec (MAR) to ensure the medications are concharted as specified	ill on a w all cords hat rrectly	
W 386	p.m., revealed that available. Further in Registered Nurse (I Care Physician and medication. A telep 2010, at 8:00 p.m., skip the medication MAR, however, failed did not receive his p 483.460(I)(4) DRUG RECORDKEEPING. The facility must, on reconcile the receip controlled drugs in a subject to the Comp Prevention and Con		W 386	- Once monthly, the facility's RN will red the LPNs to demon the proper charting medications not administered.	quest strate	09/04/11

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		.09G056	B. With	I G		07/2	0/2011
NAME OF P	ROVIDER OR SUPPLIER			13	EET ADDRESS, CITY, STATE, ZIP CODE 321 EMERSON STREET NW /ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 386	Continued From pa	ge 9	w:	386			:
	Surveyor: 18886 Based on observativerification, the faci records of the rece- controlled drugs, for sample. (Client #3) The finding include: The facility failed to accurate disposition of the July 18, 2011, at 7: #1 was administered in the client received in the package. Second the client received in the package	provide evidence of the n of the Controlled Schedule III cribed for Client #1 as evening medication pass on 15 p.m., revealed that Client and Phenobarbital 60 mg. censed practical nurse (LPN) an administration revealed that the aforementioned medication seizure disorder. She further nedication was a Scheduled III se. Review of the individual of substance record on July 18, there were thirteen tablets in ands later, the surveyor parbital pills and there were PN confirmed the that there			W 386 - The facility's RN withe LPNs on correct charting of the receand disposition of controlled substant of acility's RN will receive the LPNs to demonsthe proper proceducharting of controlled substances - The RN will conduct monthly audits of a MARs and controlled substances to ensurproper documental	t eipt ces quest strate ure for led t ill ed re	09/04/11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G056 07/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW **COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CRDSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) W 386 Continued From page 10 W 386 a separate individual resident's controlled substance sheet should have been completed for the additional three tablets sent in June 2011. However there was no individual resident's controlled substance record to verify the nurse' interview. There was no evidence that the facility's staff correctly recorded the receipt, disposition and monitoring of the receipt or disposition for the Controlled Schedule III Drug (Phenobarbital).

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-134 07/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1321 EMERSON STREET NW** COMP CARE !! WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY 1 000 INITIAL COMMENTS 1000 Surveyor: 18886 A licensure survey was conducted from July 18. 2011 through July 20, 2011. A sample of three residents was selected from a population of five men with various intellectual and developmental disabilities. The findings of the survey were based on observations at the group home and at one day program, interviews clients and staff and the review of clinical and administrative records. including incident reports. 1090 3504.1 HOUSEKEEPING 1090 The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Surveyor: 19326 Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observations during the environmental walk-thru and interview with the House Manager (HM) on July 19, 2011, beginning at approximately 11:20 a.m., revealed the following: 1. The kitchen wall above the stove had grease on it. The hood above the stove had grease on it.

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Idm. Asst.

(X6) DATE

8/15/11

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-134		(X2) MULTI A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED		
		NFD03-134		7-02 2-04		07/2	20/2011
COMP C	PROVIDER OR SUPPLIER		1321 EME	RSON STRI TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1 092	3. In resident #4's accumulation of delens cover. 4. In the basement an accumilation of of the above cited deby the facility House approximately 1:00 get on these deficies 3504.3 HOUSEKES Each GHMRP shall and vermin. This Statute is not Surveyor: 19326 Based on observation the environment was vermin, to ensure the environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top. At appronducting an environment was revealed by a smaches were obsercounter top.	or half bathroom ceiling chipping and peeling bedroom there was a ad bugs on the ceiling behind the washing dust was observed. ficiencies were acknown Manager on July 2' p.m. who indicated surcies right away. EPING The free of insects, rown the facility failed to see the aith and safety one health and safety of the property of the safety of the peeling and peeling the safety of the peeling and peeling the peeling the peeling and peeling the peeling and peeling the pe	paint. In glight machine, owledged 1, 2011 at he would idents o ensure ents and of all o a.m., it that citchen , while roaches kitchen kitchen	i 090	1. The hood has be cleaned 2. The second floo bathroom has be repainted 3. The ceiling light cover has been of the area behind washing maching been cleaned 4. The area behind washing maching been cleaned 6. Once monthly, the facility's maintendivision and the Manager will continue and extensive compliant regulatory standing the standard standa	r hall een lens cleaned the e has he nance House nduct ernal udits to ce with	08/12/1:

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-134 07/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY 1092 092 Continued From page 2 T 092 A meeting was held with Following the environmental inspection, interview with the house manager (HM) revealed that the the pest control facility was just sprayed for the roaches on July contractor to discuss the 18, 2011, and that the facility had a current deficient finding. A contract with a pest control company. On July 19, 2011, at approximately 12:15 p.m., review of the rigorous approach to pest previous invoices revealed the facility had been termination was treated for roaches on June 6, 2011, June 20, promised by the 2011, July 5, 2011, and July 11, 2011. It was pointed out to the HM the invoices only indicated exterminator that these services took place and did not Once monthly, the indicate what was used to eliminate the condition. exterminator will conduct Also, it was brought to the attention of the HM that the pest control company failed to sign the environmental audits to visitor's log when they were in the facility. The determine the HM acknowledged these findings this same day. effectiveness of and feels that they have a contract with a pest treatment control company not able to provide a insect free environment. The facility's House Manager will also The facility failed to ensure an insect free conduct monthly environment as required by this section. environmental inspection 1206: 3509.6 PERSONNEL POLICIES 1206 to ensure effectiveness of treatment. 08/12/11 Each employee, prior to employment and annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Surveyor: 19326 Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to show evidence of a physician's

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-134 07/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY 1206 Continued From page 3 1206 I 206 The employee has certification that documented a health inventory had been performed, for one (1) of twelve (12) submitted a current employee records reviewed. (Employees #3). health certificate Further, no current physicians certification was The LPNs, the pharmacist, documented for consultants, two LPNs the Pharmadist or the Occupational Therapist. and the occupational therapist have submitted The findings include: health certificates On July 19, 2011, beginning at approximately certifying that they are 12:30 p.m., a review of the personnel records free of communicable revealed that one of twelve employees did not diseases have a current health certificate, for employees #3, nor was there evidence that two LPN's the The facility's Assistant Pharmacist or the Occupational Therapist had Administrator will been certified free from communicable diseases. conduct monthly audits This was acknowledged by the Program Manager (PM) on the same day at approximately 3:00 p.m. of personnel and consultant records to 1401 3520.3 PROFESSION SERVICES: GENERAL I 401 ensure compliance with **PROVISIONS** regulatory standards. Professional services shall include both diagnosis 08/12/11 and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Surveyor: 18886 Based on observation, interview and record review, the Group Home for with Intellectually Disabilities (GHPID) failed to ensure professional services were provided in accordance with the recommended needs, for two of the five residents residing in the facility. (Residents #1 and #4) The findings include:

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-134 07/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1321 EMERSON STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 4 1401 1401 I 401, 1 1. On July 18, 2011, at 4:25 p.m., Resident #1 The facility's Registered was observed entering the facility using a seated Nurse will, on a weekly roller walker. During medication observations on basis review all medical July 18, 2011, at 7:15 p.m., revealed Resident #1 records to ensure that receiving Seroquel 25 mg. Interview with the licensed practical nurse (LPN) after the recommendations are medication administration revealed that the carried out in a timely resident received the medication for his diagnosis of schizophrenia. manner for all clients in the facility. Review of Resident #1's medical record on July A tracking system will be 19, 2011, beginning at 8:45 a.m., revealed a put in place to capture psychotropic medication review consultation form dated May 16, 2011. The psychiatrist recommendations and recommended that the resident see a neurologist timely follow-up. due to his deterioration in gait. Further review of On a quarterly basis, the the medical record revealed a neurologist consult dated March 2011. facility's RN and QIDP will review all medical Interview with the LPN on July 19, 2011, at records to ensure that approximately 10:30 a.m., Indicated that she schedules all medical appointments for Resident recommendations are #1. She further confirmed that a neurology adhered to in a timely consult had not been schedule. There was no manner. evidence that a neurology consult had been made after the psychiatrist made the recommendation 09/04/11 for consultation. 2. The facility's nurse failed to ensure that medications were properly destroyed, for one of the three residents in the sample. During medication administration on July 18, 2011, at 7:15 p.m., revealed the medication nurse dropped two of Resident #1's Divalproex ER tablets (one on the counter top and one on the floor). Interview with the medication nurse at 7:42 p.m., indicated that she was going to flush the tablets

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I 401	down the toilet. At nurse was observed medicine cup and a she indicated she pure to dissolve the medication nurse flucture of the toilet. Interview with the R 19, 2011, at approximat medications should be again along with coff Review of the facility.	7:58 p.m., the medic d putting the two tab adding water. In an input the water in the matablets. At 8:01 p.m. ushed the undissolve degistered Nurse (RN imately 10:30 a.m., rould be disposed of ations, putting it into a	lets in a Interview edicine , the ed tablets I) on July evealed by a zip lock 2011, at	I 401	I 401, 2 - The medication number on the facility's polarized discarding medicate concernments. The mediation number demonstrate the procedure for discardinal medication.	riced licy of lion quest les to roper	09/04/11
I 420	discarding/disposing 3. [See W386]. The records of the receive controlled drugs, for sample. 4. [See W369]. The medications were a one of the five residence of the five reside		intain all nts in the sure that error, for acility. and acquire cope air um levels g.	l 42 0	I 401, 3 - Please refer to W 3 I 401, 4 - Please refer to W36		

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING HFD03-134 07/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW **COMP CARE II** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1420 Continued From page 6 1420 Retarded Persons (GHMRP) failed to ensure that residents received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT), for two of the three residents in the sample. (Residents #1 and #2) The findings include: 1. During dinner observations on July 18, 2011, at 6:00 p.m., revealed Resident #1 with missing top teeth. Interview with the staff indicated that he does not require a modified diet texture during meals. Review of Resident #1's medical record on July 19, 2011, beginning at approximately 8:45 a.m. revealed a dental consultation form dated February 8, 2011. The consultation form noted that the resident had heavy tarter with heavy bleeding. It was recommended that he needed assistance with brushing his teeth two to three times per day. Review of the Resident #1's Community & Home Life Assessment dated October 6, 2008, on July 19, 2011, at 10:00 a.m., revealed a section labeled oral hygiene. The assessment indicated that the resident required physical assistance to brush his teeth thoroughly and flossing. Review of the IPP dated October 5, 2010, on July 19. 2011, at 11:00 a.m., revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment. The Qualified Intellectual Disabilities Professional (QIDP) verified on July 19, 2011, at approximately 12:45 p.m., that no training programs had been developed for the resident to participate in a

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTH A. BUILDING B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPLI		
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	Continued From page 7 toothbrushing program as recommended in the assessments. 2. During dinner observations on July 18, 2011, at 6:03 p.m., revealed Resident #3 eating a finely chopped dinner. He was also observed with missing teeth. Interview with the staff indicated that he does required a finely chopped diet. Review of Resident #3's medical record on July 19, 2011, beginning at approximately 2:50 p.m., revealed a dental consultation form dated March 15, 2011. The consultation form noted that the resident had heavy tarter with moderate bleeding. It was recommended that he needed assistance with brushing his teeth two to three times per day. Review of the Resident #3's Community & Home Life Assessment dated January 9, 2009, on July 19, 2011, at 4:00 p.m., revealed a section labeled oral hygiene. The assessment indicated that the resident required physical assistance to brush his teeth thoroughly and flossing. Review of the IPP dated January 11, 2011, on July 19, 2011, at 4:30 p.m., revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment.			1420	I 420, 1 & 2 The Qualified Intellipisabilities Profess (QIDP) will review consults for all clienthe facility Individual Program (IPP) of tooth brush will be developed for Clients # 1, # 3, and others affected by deficiency The QIDP will train on implementation program goals Program goals will reviewed quarterly QIDP for progress of progress and modification made deemed fit.	ional dental nts in Plan hing for this staff of the be by the or lack	09/04/11	
:	(QIDP) verified on J 12:45 p.m., that no developed for the re	lectual Disabilities Pro July 19, 2011, at appi training programs ha resident to participate tram as recommende	proximately ad been in a					
1 422	3521.3 HABILITATI	TON AND TRAINING	<i>i</i>	1422				
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(X4) D SIAMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCES) (EACH DEFICIENCY) PREFIX TAG 1422 Continued From page 8 the resident 's Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 18886 Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that residents received habilitation and assistance as prescribed in their individual Support Plan, for one of the three residents in the sample. (Resident #3) The findings include: Observations, interviews and record review revealed that Resident #3 did not participate in his exercise program to ride a stationary blike, as evidenced by the following: Resident #3 was observed on July 18, 2011, from 4.12 p.m. (when he and his peers arrived home from day program) until 8:00 p.m. Upon his arrival home, he want to his bedroom and used the bathroom. At 4.30 p.m., his housemates had a snack. Staff want up to the resident bedroom and asked if he wanted to have a snack. From 4.36 p.m., until 5.20 p.m., the resident stayed in his bedroom. At 8.30 p.m., the resident stayed in his bedroom. At 8.30 p.m., the resident sealent stayed in his bedroom and caked the resident to play table top games. He played for approximately 10 minutes and then indicated the "played enough." At 5.50 p.m., Resident &3 assisted with setting the table for dinner. He put the placemats and glasses on the table in preparation for dinner. At 6.03 p.m., the resident number arrived in the facility and began administering medications at 6.50 p.m., the medication nurse arrived in the facility and began administering medications at 6.50 p.m., the medication nurse arrived in the facility and began administering medications at 6.50 p.m., the medication nurse arrived in the facility and began administering medications at 6.50 p.m. the resident tendence to the facility and began administering medications at 6.50 p.m. the resident tendence to the facility and began administering medications at 6.50 p.m. th	NAME OF PROVIDER OR SUPPLIER STREET ADD								
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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-134 07/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1321 EMERSON STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY 1422 Continued From page 9 1422 I 422 The facility's QIDP will care staff on July 18, 2011, at 7:45 p.m., revealed that Resident #3 requested to have his shower train staff on accurate and staff assisted him. documentation of program goals On July 19, 2011, at 1:00 p.m., review of Resident #2's Individual Program Plan (IPP) The facility's House dated October 25, 2010, revealed a program Manager and QIDP will objective which stated, "Three times per week, on a weekly basis given physical assistance, he will ride a stationary bike for five minutes per session, times three monitor implementation sessions (15 minutes) 60% of recorded trials per and documentation of month." He was to receive said training on program goals for all Mondays, Wednesdays and Fridays. However, Resident #2 and facility staff were observed on clients in the facility to Monday, July 18, 2011, from 4:12 p.m. until 8:15 ensure accurate data p.m. and at no time was an exercise activity collection. Monitoring of observed during the observation period. program implementation Interview with the House Manager and QIDP on and data collection will July 19, 2011, at approximately 10:30 a.m., be carried out for three confirmed that the resident did not participate in months to ensure that the exercise activity. significant emphasis is put on accurate data collection by staff Data on program goals will be reviewed monthly by the QIDP to ensure consistency in program implementation and data collection. 09/04/11 Health Regulation & Licensing Administration